IN-DEPTH TECHNICAL ASSISTANCE PROGRAM
NATIONAL CENTER ON SUBSTANCE ABUSE AND CHILD WELFARE
DISTRICT OF COLUMBIA FINAL REPORT

The District of Columbia Child and Family Services Agency (CFSA) requested technical assistance from the National Center on Substance Abuse and Child Welfare (NCSACW) on July 2012. The initial request was for assistance in adopting and implementing a substance use-screening tool that would help child welfare workers objectively screen for substance use concerns in parents and youth involved or at risk of involvement with CFSA.

Over the next several months, the NCSACW worked with the site to collect and analyze data to better understand the current system, identify gaps in services, and ascertain the willingness and readiness of partner agencies to collaborate. The Addiction Prevention and Recovery Administration (APRA), the Department of Youth Rehabilitation Services (DYRS), and the DC Superior Court to defined shared goals and objectives for improving services for children and families affected by substance use disorders.

The NCSACW Contracting Officer Representatives (CORs) from SAMHSA and the Children's Bureau approved the In-Depth Technical Assistance (IDTA) application and Scope of Work (SOW) on February 2013. The IDTA Program Director served as Consultant Liaison (CL) for this site, providing technical assistance and monitoring progress with their SOW through weekly calls with CFSA staff and partners through September 2013 and bi-weekly calls through September 11, 2014. Site visits on December 2012, July 2013 and April 2014 involved meeting with District of Columbia agency leaders and IDTA Core Team members to discuss progress, challenges encountered, and next steps. On September 9, 2014, a final closeout meeting took place with the site. CORs from SAMHSA and Children's Bureau attended the meetings.

In-Depth Technical Assistance is provided in phases designed to facilitate systems change within and across departments. General time frames are associated with each phase with progress closely monitored by the CL.

Phase 1: Assessment of Need and Readiness for Change (Up to 6 months) — Activities during this stage are designed to assist the sites in clearly defining their needs, the issue(s) they intend to resolve and their capacity to do so through this process. This phase also forms the foundation for successful engagement and retention of partners, policy makers and other critical stakeholders. Participants in this phase will increase their awareness of the issues and their understanding of the need for change.

Phase 2: Strategic Planning and Capacity Building (Up to 6 months) — Using the data and information gathered during Phase 1, the NCSACW and the sites will work together during Phase 2 to develop mutual priorities for practice and policy changes. The sites will develop a strategic plan for pilot testing these changes in Phase 3. Identification of specific practice and policy changes needed, and the commitment of partners to make such changes is essential during this phase.

Phase 3: Implementation and Evaluation (Up to 6 months) — Phase 3 is focused on pilot testing the program, practice or policy changes identified in Phase 2, and evaluating and making the necessary adaptations and adjustments needed. Training all stakeholders, developing a common language, and gaining a deeper understanding of each other's systems are critical in this phase. Using the principles of rapid-cycle testing to accommodate implementation-specific evaluation, sites will be required to pilot their change strategies at the local level to obtain feedback about what works

and what does not and to ensure that the project's outcomes reflect the improvements envisioned. Participants in Phase 3 demonstrate knowledge of and ability to make cross-system changes and institute collaborative practice(s).

Phase 4: Dissemination, Evaluation and Sustainability Planning (Up to 6 months) — In this phase, sites focus on developing concrete steps for broad-based dissemination, including the identification of resources needed to continue to evaluate the impact of their effort. Institutionalizing and sustaining those activities that result in positive change is the goal of this phase. Participants in Phase 4 demonstrate the ability to monitor their progress against baseline measures and plan for moving from pilot to true systems change. Sites will complete their participation in IDTA with a Wrap-Up meeting in which they will present their preliminary evaluation results, accomplishments, challenges, and next steps to the Oversight and Advisory Committee and other community stakeholders.

Phase 5: Follow up, Monitoring and aftercare (up to 6 months post-IDTA) — Periodic check-ins with the sites are designed to reinforce and assist in sustaining change and to address remaining or emerging challenges.

COLLABORATIVE LEADERSHIP STRUCTURE

The **Oversight Committee** was comprised of agency leaders from the five primary partners. This committee provided project oversight, including initial direction, review, and approval of policy and practice recommendations and assurance of active participation by each agency's designated staff. The Oversight Committee committed to ensuring the effective use of IDTA resources, to providing support and direction to the Core Team as needed, and to resolving barriers and challenges in a timely fashion; resulting in the successful and timely completion of the project. Members included:

- DC Child and Family Services Agency (CSFA), Brenda Donald, Director
- Addiction Prevention and Recovery Administration (APRA), Frances Buckson, Interim Deputy Director
- Department of Mental Health (DMH), Marie Morilus-Black, Director
- Department of Youth Rehabilitation Services (DYRS), Neil Stanley, Director
- DC Superior Court (DCSC), Honorable Zoe Bush, Presiding Judge

The **Core Team** was comprised of project leaders and managers with sufficient level of responsibility to ensure activities and recommendations were carried out in a timely manner. The Core Team was responsible for the completion of goals and activities identified in the SOW, for demonstrating active involvement of each partner agency in the completion of goals and objectives, for addressing barriers and communication problems in a timely fashion and for keeping their respective Oversight Committee member informed of their progress, challenges and barriers and emerging issues. Members included:

- Michele Rosenberg, CFSA, Chief of Staff, Project Lead
- Amy Templeman, CFSA, Office of Well-Being Supervisor
- Nkechi C. Onwuche, CFSA, Nurse Care Manager
- Valerie Kanya, CFSA, Substance Abuse Coordinator
- Ora Graham, CFSA, Program Manager, Mayor's Services Liaison Office
- Christopher Keeley, CFSA, Supervisory Social Worker
- Jennifer Etienne-Valtrin, CFSA, Social Worker
- Todd Menhinick, APRA, Chief of Quality Assessment
- Carol Zahm, DMH, Project Director
- Sarah Aleem, DYRS, Manager, Health Services

- Stephanie Minor-Harper, DCSC, Family Court Coordinator
- Leslie Gross, Office of Attorney General, Section Chief

The **Oversight Committee** also included other members who served in an advisory capacity, adding needed expertise and authority to sufficiently address the overall goals and objectives of this project, including:

- Debra Porchia-Usher, CFSA, Principal Deputy Director
- Sandra Gasca-Gonzalez, CFSA, Deputy Director, Entry Services
- Cheryl Durden, CFSA, Administrator, Clinical and Health Services
- Sarah Thankachan, CFSA, Administrator, Office of Youth Empowerment
- Valerie Douglas, CFSA, Administrator, Contract Management and Performance Improvement
- Brady Birdsong, CFSA, Chief Information Officer
- Andrea Guy, CFSA, Deputy Director for Planning, Policy, and Program Support
- Jasmine Hayes, CFSA, Administrator, Planning, Data, and Quality Assurance
- Cory Chandler, Office of Attorney General, Deputy Attorney General
- Javon Oliver, APRA, Director of Treatment Service, Alina McClerklin, APRA, Performance Manager
- Barbara Bazron, DMH, Deputy Director, Programs & Policy
- Amanda Petteruti, DYRS, Program Analyst
- Garine Dalce, DYRS, Acting Chief of Committed Services
- Evette Jackson, DYRS, Acting Program Manager
- Tony Saudek, DYRS, Research and Evaluation Officer
- Douglas Garland, DYRS, Case Manager Supervisor
- Honorable S. Pamela Gray, DCSC, Judge
- Honorable Zoe Bush, DCSC, Judge
- Terri Odom, DCSC, Director, Family Court Social Services
- Nancy Ware, Court Services and Offender Supervision Agency, Executive Director
- Anniglo Boone, Consortium for Child Welfare, Executive Director

Washington's leaders identified the following mission, target population, goals and short and long-term outcomes for this IDTA project.

MISSION

CFSA, APRA, DYRS, Department of Mental Health (DMH), and the Family Court, and other agencies as needed, will work collaboratively to ensure the identified target populations of children, youth and adults receive timely screening, assessment, referral and engagement in treatment services as needed to address their substance use and co-occurring mental disorders with effective treatment. Through joint accountability and shared outcomes, partners will address the safety permanency and well-being needs of the children and youth at risk of or in out-of-home placements, the recovery and well-being needs of parents/caregivers, and therefore the overall well-being of the family.

TARGET POPULATION

- Parents/caregivers with substantiated child abuse and/or neglect cases and children 0-5 years old
- Youth ages 11 and older in out of home care
- Youth ages 11 and older remaining at home and receiving in-home services

GOALS

Goal 1: Screening and Assessment — Potential substance use and co-occurring mental disorders are identified in a consistent, uniform, and timely manner.

Goal 2: Engagement and Retention — Youth and parents/caregivers in the target populations are engaged and retained; services are provided to address their substance use and co-occurring disorders.

Goal 3: Data and Information Sharing — Partners use interagency communication protocols to share client and systems level information.

Goal 4: Joint Accountability and Shared Outcomes — Partners have developed a collaborative practice approach to serving children, youth, and families that intersect with each of their systems.

Goal 5: Services for Children, Youth and Parents/Families — Partners have agreed upon evidence-based practices and programs that meet the needs of the target populations; they have processes in place for monitoring use and effectiveness of these programs.

In May 2013, the DC partners completed the Collaborative Capacity Instrument (CCI). This self-assessment tool is intended to be used by State (and/or local jurisdiction) alcohol and other drug (AOD) service and child welfare service (CWS) agencies, dependency courts and other agencies and organizations who are preparing to work with each other or who may be seeking to move to a new level of cooperation after some initial efforts. The questions elicit discussion among and within the agencies and the court about their readiness for closer work with each other.

Responses from this assessment were tabulated and discussed with the Oversight Committee, the Core Team and other advisory members during the July 2013 site visit. The CL discussed areas of greatest alignment and disagreement across the **10 Elements of Collaborative Practice** as reflected in the table below.

ELEMENTS OF COLLABORATION	DISAGREE	SOMEWHAT AGREE	AGREE	DON'T KNOW
Values & Principles	15.1%	41.9%	43.0%	13.89%
Screening & Assessment	52.90%	20.30%	26.80%	21.14%
Engagement & Retention	40.40%	27.80%	31.80%	17.65%
Children's Services	40.80%	24.00%	35.20%	16.67%
Shared Outcomes	42.40%	30.50%	27.10%	20.81%
Shared Information	40.00%	33.00%	27.00%	15.97%

Elements Of Collaboration	Disagree	Somewhat Agree	Agree	Don't Know
Training & Staff Development	45.00%	27.50%	27.50%	26.35%
Budget & Sustainability	21.79%	25.64%	52.56%	41.79%
Working with Related Agencies	19.80%	31.10%	49.10%	20.90%
Working with Community	35.90%	33.00%	31.10%	16.94%

The group stated there were no significant surprises with the results. Furthermore, they felt the results reinforced the goals and objectives they had identified to work on during their IDTA. While there appeared to be greater alignment with Values and Principles, Budget and Sustainability and Working with Related Agencies, the Core Team agreed improvement was needed in services and cross-systems communication, as indicated by greater *Disagreement* or *Don't Know* responses on the following sets of questions.

Screening and Assessment

- Our state has successfully out-stationed AOD workers at CPS offices and/or the dependency court to help with screening and assessment of clients.
- Our state supplements child abuse/neglect risk assessment with an in-depth assessment of AOD issues and their impact on each of the family members.
- Our state's child welfare intake process is able to identify prior AOD treatment episodes based on previously negotiated information sharing protocols.
- Our state's AOD intake process identifies parents who are involved in the CWS system based on previously negotiated information sharing protocols.
- Our state routinely documents AOD factors from its screening and assessment process in the information system.

Engagement and Retention

- Our state's CWS staff have the skills and knowledge to talk with their clients about their AOD use and related problems.
- Our state's AOD staff have the skills and knowledge to talk with their clients about child safety and CWS involvement.
- Our systems have assessed common dropout points where clients in care leave the system prior to completing treatment.
- Our state's CWS staff provides outreach to clients who do not keep their initial AOD appointment or drop out of treatment.
- Our state has developed and trained our staff in approaches with clients that improve rates of retention in treatment once they enter it.
- In our state, there is an adequate system for monitoring jointly agreed upon outcomes of child welfare, substance abuse and dependency court programs, and interventions.

Services to Children

- Our state ensures that all children in CWS are screened for substance use disorders.

Data and Information Sharing

- Our state has assessed its data system to identify gaps in monitoring clients involved in both CWS and AOD systems.
- Our state has identified the confidentiality provisions that affect CWS-AOD and dependency court connections and has devised means of sharing information while observing these regulations.
- Our state's AOD services have supplemented the alcohol/drug data system to generate data on their clients' children and their CPS involvement.
- Our state has developed the capacity to automate data about the characteristics and service outcomes of the clients who are in both the CWS and AOD caseloads.
- Our state is using data that can track CWS/AOD clients across information systems to monitor system outcomes.

Joint Accountability and Shared Outcomes

- Our state AOD, CWS agencies, and the courts have developed shared outcomes for CWS-AOD involved families and have agreed on how to use this information to inform policy leaders.

Training and Staff Development

- Our state CWS ensures that all managers, supervisors and workers receive training on working with AOD-affected families.

The CFSA staff worked with core team members from the courts, APRA and DYRS as well as other community providers on several practice changes to better address the needs of parents and youth with substance use concerns:

- Agreements on baseline data and the tools for measuring progress towards and achievement of shared outcomes
- CFSA hired a Substance Abuse Coordinator to focus on coordination, linkages, follow-up and data analysis
- CFSA implemented the Global Appraisal of Individual Needs (GAIN-SS) verbal screen, a substance abuse screening tool for youth who enter foster care or move to a new placement
- CFSA social workers received training on Screening, Brief Intervention, Referral to Treatment (SBIRT) and Motivational Interviewing; evidenced-based practices for engaging and retaining individuals with substance use and co-occurring disorders
- APRA dedicated appointment times and a dedicated assessor for adult clients to ensure timeliness to assessment
- A tracking system was developed between CFSA and APRA to track screening, assessment, entry into treatment and treatment completion
- The Family Treatment Court Model was expanded to include fathers and link parents to all levels of substance abuse treatment, not just residential care
- A Memorandum of Agreement between CFSA and APRA for Data Sharing was developed and implemented. With client consent, agencies can share individual client assessment results and treatment progress. The protocol specifies how information will be shared and with whom for the purpose of case planning and reporting on client participation and progress

The team used data and participant feedback to evaluate the effectiveness of programs and practices, making adaptations as needed based on information gathered. The tracking system that was developed to track screening, assessment, entry into treatment and treatment completion not only enabled CFSA

and APRA to track engagement and progress for individual parents and youth, but to identify barriers to effective implementation, including:

- Though workers in both systems were trained on confidentiality regulations and appropriate Informed Consents had been developed, CFSA social workers, APRA assessors, and community treatment providers were not always getting parents to sign the consents, thus prohibiting the information from being entered into the new database and shared with partners. The Substance Abuse Specialist realized that ongoing monitoring to ensure all paperwork was completed was essential for the system to work.
- Though CFSA social workers were trained on the GAIN-SS, they found the tool to be too time consuming. It should be noted that the tool was introduced at the same time as workers were being asked to identify a multitude of issues, including domestic violence, trauma and other mental health concerns as well as parental substance use. The CFSA and APRA team members believed early screening and identification of parental and youth substance use was critical and began to explore other strategies for accomplishing this.

In early 2014, the NCSACW staff worked with the site to review accomplishments since the beginning of their IDTA initiative and determine priorities for the remaining nine months. The DC Core Team members determined they would focus on the following priorities for that time period:

- Tracking screening, assessment and engagement in treatment for target population parents and youth with monthly drop-off analysis. Tracking each point of entry helped the team assess the effectiveness of the processes they developed as well as those that already existed. The DC team used this continuous quality improvement process throughout their last year.
- Core Team members finalized the Memorandum of Agreement (MOA) between the Child and Family Services Agency (CFSA) and the Addiction Prevention and Recovery Administration (APRA). Legal counsel for both agencies reviewed the document several times prior to finalizing it, focusing primarily on adhering to confidentiality regulations while being able to share client and administrative data and information between agencies. The final MOA also served as a template for a similar document between APRA and the Department of Youth Rehabilitative Services (DYRS). Using a consistent data entry system will allow sharing of confidential information across systems and tracking of CFSA and DYRS youth through the assessment and treatment process.
- Training Child Protective Investigators and Continuing Social Workers on Screening, Brief Intervention and Referral to Treatment (SBIRT) and Motivational Interviewing.
- Continuing to work with APRA to complete fields in DATA, APRA's database, for tracking individuals referred to and/or receiving assessments and treatment services and train CFSA staff on the use of this data system.
- Finalizing the cross-system indicators with the Oversight Committee, determining how data would be collected to measure progress, and developing a timeline and process for when the indicators would be shared.

As the lead agency for the DC IDTA project, CFSA's commitment to identifying and serving child welfare families for whom substance use is a major factor was especially evident during the second quarter of 2014. Monthly data collection coupled with feedback from front-line workers, supervisors, managers and other partners resulted in the identification of strategies and services to better meet the needs of children, youth, and families. During the DC annual budget process, funding was requested and approved for the following services:

- A dedicated unit of Family Recovery Specialists, two of whom would be located at the Family Drug Court and two in CFSA office. The Recovery Specialists positions were created to provide enhanced screening, assessment, and engagement of parents with substance use disorders.
- In-Home Treatment Services for families in the DC area with multiple and complex needs and that have been difficult to engage and retain in other services.

- A provider to work specifically with youth to assess and engage in treatment services. This request was developed following a meeting with youth providers in the DC and Maryland, as 33% of CFSA youth are placed in out of home care in Maryland. Providers identified the need to enhance, expand, and better coordinate services for CFSA youth with substance use and mental disorders.
- Peer mentoring programs for both parents and youth. The CFSA Peer Mentoring Program would be expanded to include parents who were successfully recovering from substance use and mental disorders. The proposed Youth Peer Mentor Program peer program would be developed for youth with substance use and mental disorders and would be funded by a combination of CFSA and Chafey funding to create a career development path for youth mentors.
- RFPs were released and providers selected for the Youth Assessor and the Family Recovery Specialists. The agency decided to release an RFP for In-Home Services at a later date.

Improving services to youth that intersected all systems, particularly those youth in Out of Home Care, continued to be a high priority for the DC core team. They also worked with the Youth Assessor provider and the Choice Providers, providing adolescent treatment services in the DC area, to address challenges with engaging and retaining youth in services. Since APRA had received a SAMHSA Adolescent Treatment grant, the team agreed they would continue to meet post-IDTA with the DC Core Team serving as the Steering Committee for the grant to ensure ongoing coordination across all systems. APRA and DYRS also began working on a cross-system data sharing elements modeled after the system developed by APRA and CFSA. They will ultimately coordinate data across all three systems.

The Oversight Committee members finalized their cross-system indicators and CFSA staff developed a plan for collecting a one-month sample of data to test measuring and reporting on indicators, with the data presented at the final IDTA Oversight Committee meeting on September 9, 2014. The committee discussed how they would continue to collect and report on the indicators.

Training CFSA caseworkers was especially important in the final months of the project. Caseworkers received training on making referrals to and sharing information with the Family Recovery Specialist and Youth Assessor programs. Foster parents were also trained on working with the Youth Assessor program as they play a critical role in the engagement and retention of youth in services for substance use and mental disorders.

The District of Columbia (DC) IDTA site completed their IDTA project on September 9 with their final Oversight Committee meeting. The core team members presented on accomplishments and challenges and lessons learned during their two years of IDTA with the NCSACW.

ACCOMPLISHMENTS

Goal 1: Screening and Assessment — Potential substance use and co-occurring mental disorders are identified in a consistent, uniform, and timely manner:

- CFSA trained all social workers and Healthy Horizons Assessment Center (HHAC) staff on Global Appraisal of Individual Needs Short Screener (GAIN-SS). HHAC implemented the screen with target population of all youth ages 11 and older who enter care or move to a new foster home. They also saw a significant increase in the number of referrals for parents with a positive screen.
- CFSA conducts a 10-panel urine screen on all youth ages 11 and older who enter care or move to a new foster home.
- CFSA and APRA coordinate appointments for clients, decreasing wait time for assessments from 14 days to 24 hours, with a dedicated assessor for CFSA clients.
- CFSA implemented a mobile assessor for youth with substance use concerns.

Goal 2: Engagement and Retention — Youth and parents/caregivers in the target populations are engaged and retained, and services are provided to address their substance use and co-occurring disorders:

- APRA facilitated training for CFSA supervisors in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol, Motivational Interviewing, and Stages of Change.
- CFSA developed SBIRT curriculum, motivational interviewing, and stages of change with Howard University.
- CFSA launched SBIRT training for social workers in May 2014.
- District of Columbia Superior Court (DCSC), APRA, CFSA, and other stakeholders identified and implemented a new model for engaging adults through Family Treatment Court. The new model includes more treatment options, incentives, recovery support, and is available to fathers.

Goal 3: Data and Information Sharing — Partners use interagency communication protocols to share information client and systems level information:

- CFSA gained access to APRA's DATA system, which allows for electronic referrals and sharing of consented information about assessment results and treatment progress.
- CFSA and DYRS are teaming on dual-jacketed youth cases to share pertinent information across systems to establish the magnitude and extent of substance use among this population in order to develop effective intervention strategies (need to look at data on team meeting attendance).
- The team implemented a quarterly drop-off analysis/data exchange between Office of Well Being, FACES staff, and APRA to help identify gaps in engagement and services.

Goal 4: Joint Accountability and Shared Outcomes — Partners have developed a collaborative practice approach to serving children, youth, and families that intersect with each of their systems:

- APRA and CFSA are continuing to develop a comprehensive cross-training program wherein each system can learn the philosophy and terminology of the other. Both agencies believe this facilitates more meaningful service delivery and joint decision-making.
- Shared indicators were established and agreed upon by all agencies to measure client outcomes, which include:
- Children remain at home
- Children remain at home
- Length of stay in out-of-home care
- Recurrence of child maltreatment
- Re-entry into foster care
- Timeliness to reunification
- Timeliness to permanency
- Access and completion of substance abuse treatment
- Timeliness of assessment and treatment entry

The DC Core Team identified a number of challenges and lessons learned over the course of their IDTA project, including:

- Understanding each other's systems, beliefs about and approaches to parental substance use, referral processes, flow charts and logic models, roles and responsibilities, and language they use to talk about families and children was essential in the beginning if we were to work together effectively.

- We did not realize how important it is to assess client readiness for treatment and how to motivate them to engage.
- Understanding how trauma affects clients with substance use disorders.
- The importance of making and keeping the commitment to a better-trained workforce is a high priority across all systems.
- It was easy to agree on one universal screening tool, the GAIN-SS, but much more difficult to share results of that tool with other systems.
- Social workers and families respond when they see collaboration in action (e.g., youth mobile assessor).
- All partners developed a respect for ongoing questioning of processes and focusing on continuous quality improvement.

NEXT STEPS

The IDTA Program Director will conduct monthly calls with the site throughout the 2014-15 NCSACW contract year to assess continued progress and identify ongoing or emerging challenges, concerns, and technical assistance needs. The DC team has committed to continuing work in the following areas:

- Team members will continue to meet as the Steering Committee for the ACRA grant to support youth co-occurring disorders and maintain close communication across all agencies.
- CFSA and DYRS will continue work on dual-jacketed youth.
- APRA-DYRS will continue to monitor the use of the DATA system for tracking parents and youth from assessment through treatment completion.
- CFSA and APRA staff will continue to monitor and evaluate the following:
  - Continuing to monitor screening, assessment, engagement and retention for adults and youth
  - Monitoring treatment capacity and effectiveness for child welfare involved adults, youth and families
  - Monitoring indicators & client outcomes
- The DC Core Team and will complete an evaluation of NCSACW technical assistance and submit all final products to Linda Carpenter by December 2014.

PRODUCTS SUBMITTED

- Memorandum of Agreement between CFSA and APRA
- Cross System Shared Indicators